

KANSAS MEDICAID STATE PLAN

Attachment 4.19-B

#3

~~Replacement Page 12-05-90~~

Other Laboratory and X-ray Services  
Methods and Standards for Establishing Payment Rates

Laboratory and x-ray services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

Reimbursement for physician-referred laboratory services performed by an independent laboratory shall be made directly to the laboratory.

KANSAS MEDICAID STATE PLAN

Attachment 4.19B

Methods and Standards for Establishing Payment Rates <sup>4a</sup>

#4a Skilled Nursing Facility Services for  
Individuals 21 Years of Age or Older

See Attachment 4.19-D

State Plan MS-83-37

Trans. No. ~~9-28-83~~

Submitted 9-28-83

Approved 11-22-83

Substitute per letter dated 11/9/92<sup>m</sup>

KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#4.b.

Methods and Standards for Establishing Payment Rates

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT screens are reimbursed on the basis of reasonable fees as related to Medicaid customary charges except no fee is reimbursed in excess of a Statewide maximum. Provider representatives and the EPSDT Advisory Committee are consulted in reviewing the maximum rate.

Agency staff will individually review claims for medically necessary services not normally covered under the plan when these services are provided to an EPSDT participant. Staff will consult with agency medical experts and compare the service to comparable services and determine a price based on expert advice and rates for similar services.

KANSAS MEDICAID STATE PLAN

Attachment 4.19B

Methods and Standards for Establishing Payment Rates

4c

#4c Family Planning Services

Payment to health departments for family planning services are based on fee maximums determined by the Department.

See Attachment 4.19B#5 for physician's services.

State Plan

Trans. No. MS 83-39

Submitted 9-28-83

Approved 11-22-83

KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#5

Methods and Standards for Establishing Payment Rates

#5 Physician's Services

Physician's services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges, except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

Payment for physician extender services are limited to a maximum of 75% of the maximum reimbursement to the billing physician.

Reimbursement for physician-referred laboratory services performed by an independent laboratory or outpatient hospital department, shall be made directly to the independent laboratory or outpatient hospital department.

TN # MS-85-08 Approval Date 4/5/85 Effective Date 1/1/85 Supersedes TN# unnumbered

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#5, Obstetrical  
Practitioner Services  
Page 2

## Physicians' Services Obstetrical Practitioner Services Methods and Standards of Established Payment Rates

### Explanation of Method and Standards of Established Fee for Service Payment Rates

This report is based on information collected by the fiscal agent from SFY1995 paid claims for the period of the fiscal year (July 1, 1994 - June 30, 1995). For this report, fiscal year data is used to provide an average payment rate per procedure code for SFY '95, the second previous year. Regardless of current maximum reimbursement rates, providers are instructed to bill their usual and customary charge.

**Procedure Code:** This reflects the CPT code for a specific medical procedure.

**Procedure Description:** This reflects the CPT nomenclature for the specified procedure code. Due to availability of space, the description may be shortened or abbreviations utilized.

**Current Rate:** This reflects the maximum rate currently reimbursed by the Kansas Medicaid program for the specified procedure code. Rates do not vary by geographic location of provider.

## KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#5, Obstetrical  
Practitioner Services  
Page 2a

### Physicians' Services Obstetrical Practitioner Services Methods and Standards of Established Payment Rates

#### Explanation of Method and Standards of Established HMO Payment Rates

HMO rates were established using the fee for service rates for obstetrical services in calendar year 1995 which is then inflated to the present time. The first HMO for Medicaid started on 12/1/95.

Due to the methodology used to establish HMO rates, there should be no direct affect due to the rate setting methodology upon Obstetrical access.

# KANSAS MEDICAID STATE PLAN

Substituted per letter dated 5/8/97 "

Attachment 4.19 - B

# 5, Obstetrical

Provider Access

Page 2B

## OBSTETRICAL PROVIDER ACCESS

#	GEOGRAPHIC AREA	H & E LICENSED	PARTICIPATING IN THE MEDICAID PROGRAM	% PARTICIPATION
1	CHANUTE	34	28	82.4%
2	EMPORIA	44	22	50.0%
3	GARDEN CITY	56	54	96.4%
4	HAYS	48	48	100.0%
5	HIAWATHA	25	24	96.0%
6	HUTCHINSON	75	35	46.7%
7&9	KANSAS CITY /METRO	344	262	76.2%
8	MANHATTAN	55	44	80.0%
10	OSAWATOMIE	50	21	42.0%
11	PARSONS	48	18	37.5%
12	PITTSBURG	20	16	80.0%
13	PRATT	56	46	82.1%
14	SALINA	51	34	66.7%
15	TOPEKA	101	60	59.4%
16	WICHITA	308	170	55.2%
17	WINFIELD	58	21	36.2%
	TOTAL	1,373	903	65.8%

TN# MS-97-06 App Date MAY 14 1997 Eff Date APR 1 1997 Supercedes MS-96-04



# KANSAS MEDICAID STATE PLAN

## Physicians' Services Obstetrical Practitioner Services

Attachment 4.19 - B

# 5, Obstetrical Practitioner Services

Page 2C

PROCEDURE CODE	PROCEDURE DESCRIPTION	AVERAGE PAYMENT AMOUNT AS OF 7/1/95	MAXIMUM RATE
590000000	AMNIOCENTESIS, ANY METHOD		\$79.51
590120000	CORDOCENTESIS (INTRAUTERINE), ANY METHOD		\$150.00
590150000	CHRONIC VILLUS SAMPLING, ANY METHOD		Non-Covered
590200000	FETAL CONTRACTION STRESS TEST		\$60.00
590250000	FETAL NON-STRESS TEST		\$32.00
590300000	FETAL SCALP BLOOD SAMPLING		\$75.00
590500000	INITIATION AND/OR SUPERVISION OR INTERNAL FETAL MONITORING DURING LABOR BY CONSULTANT WITH REPORT (SEPARATE PROCEDURE); SUPERVISION & INTERPRETATION		Non Covered
590510000	INITIATION AND/OR SUPERVISION OR INTERNAL FETAL MONITORING DURING LABOR BY CONSULTANT WITH REPORT (SEPARATE PROCEDURE); INTERPRETATION ONLY		Non Covered
591000000	HYSTEROTOMY, ABDOMINAL		\$372.26
591200000	SURGICAL TREATMENT OF ECTOPIC PREGNANCY; TUBAL OR OVARIAN, REQUIRING SALPINGECTOMY AND/OR OOPHORECTOMY		\$551.11
591210000	WITHOUT SALPINGECTOMY AND/OR OOPHORECTOMY		\$450.00
591300000	ABDOMINAL PREGNANCY		\$484.66
591350000	INTERSTITIAL, UTERINE PREGNANCY REQUIRING TOTAL HYSTERECTOMY		\$690.00
591360000	INTERSTITIAL, UTERINE PREGNANCY WITH PARTIAL RESECTION OF UTERUS		\$550.20
591400000	CERVICAL WITH EVACUATION		\$300.00
591500000	LAPAROSCOPIC TREATMENT OF ECTOPIC PREGNANCY W/O SALPINGECTOMY AND/OR OOPHORECTOMY		\$400.83
591510000	WITH SALPINGECTOMY AND/OR OOPHORECTOMY		\$544.64
591600000	CURETTAGE, POSTPARTUM		\$204.19
592000000	INSERTION OF CERVICAL DILATOR		\$48.46
593000000	EPISIOTOMY OR VAGINAL REPAIR ONLY, BY OTHER THAN ATTENDING PHYSICIAN		\$117.14
593200000	CERCLAGE OF CERVIX, DURING PREGNANCY; VAGINAL		\$156.96
593250000	ADOMINAL		\$241.28

Note: When average payment amounts are higher than current rates, it is due to the encounter rate payment methodology for Rural Health Clinics and Federally Qualified Health Centers. These providers receive all-inclusive, cost-based reimbursement. Rates do not vary by geographic area.

TN# MS-97-06 App Date MAY 14 1997 Eff Date APR 1 1997 Supercedes MS-96-04

# KANSAS MEDICAID STATE PLAN

## Physicians' Services Obstetrical Practitioner Services

Attachment 4.19 - B

# 5, Obstetrical Practitioner Services

Page 20

PROCEDURE CODE	PROCEDURE DESCRIPTION	AVERAGE PAYMENT AMOUNT AS OF 7/1/95	MAXIMUM RATE
593500000	HYSTERORRHAPHY OF RUPTURED UTERUS		\$313.02
594000000	TOTAL OBSTETRIC CARE (ALL-INCLUSIVE, "GLOBAL" CARE) INCLUDES ANTEPARTUM CARE, VAGINAL DELIVERY (WITH OR WITHOUT EPISIOTOMY, AND/OR FORCEPS OR BREECH DELIVERY) AND POSTPARTUM CARE	\$1,358.98	\$1,326.89
594090000	VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY, FORCEPS OR BREECH DELIVERY) (SEPARATE PROCEDURE)	\$734.08	\$666.02
594100000	VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY, FORCEPS OR BREECH DELIVERY) INCLUDING POSTPARTUM CARE (SEPARATE PROCEDURE)	\$808.11	\$690.19
594120000	EXTERNAL CEPHALIC VERSION, WITH OR WITHOUT TOCOLYSIS	Non-Covered	Non-Covered
594140000	DELIVERY OF PLACENTA FOLLOWING DEL'RY OUTSIDE OF HOSP	\$50.00	\$50.00
594250000	ANTEPARTUM CARE ONLY; 4-6 VISITS (SEPARATE PROCEDURE)	\$131.35	\$192.00
594260000	ANTEPARTUM CARE ONLY; 7 OR MORE VISITS (SEPARATE PROCEDURE)	\$254.85	\$425.00
594300000	POSTPARTUM CARE ONLY (SEPARATE PROCEDURE)	\$73.58	\$75.00
595100000	ROUTINE OBSTETRIC CARE INCLUDING ANTEPARTUM CARE, CESAREAN DELIVERY, AND POSTPARTUM CARE	\$1,644.85	\$1,496.23
595140000	CESAREAN DELIVERY ONLY	\$673.97	\$916.91
595150000	CESAREAN DELIVERY ONLY INCLUDING POSTPARTUM CARE	\$1,130.90	\$940.91
595250000	HYSTERECTOMY AFTER CESAREAN DELIVERY	\$250.00	\$250.00
598120000	TREATMENT OF SPONTANEOUS ABORTION, ANY TRIMESTER, COMPLETED SURGICALLY		\$250.57
598200000	TREATMENT OF MISSED ABORTION, COMPLETE SURGICALLY FIRST TRIMESTER		\$261.51
598210000	TREATMENT OF MISSED ABORTION, COMPLETE SURGICALLY SECOND TRIMESTER		\$255.87
598300000	TREATMENT OF SEPTIC ABORTION		\$366.96
598400000	INDUCED ABORTION, BY DILATION AND CURETTAGE		\$228.77
598410000	INDUCED ABORTION BY DILATION AND EVACUATION		\$259.59
598500000	INDUCED ABORTION, BY ONE OR MORE INTRA-AMNIOTIC INJECTIONS		\$346.08
598510000	WITH DILATION AND CURETTAGE AND/OR EVACUATION		\$350.00
598520000	WITH HYSEREOTOMY (FAILED INTRA-AMNIOTIC INJECTION)		\$350.00

Note: When average payment amounts are higher than current rates, it is due to the encounter rate payment methodology for Rural Health Clinics and Federally Qualified Health Centers. These providers receive all-inclusive, cost-based reimbursement. Rates do not vary by geographic area.

TN# MS-97-06 App Date MAY 14 1997 Eff Date APR 1 1997 Supersedes MS-96-04